Arkansas Public School Employees

Guide To Healthcare Choices

Effective:
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www.accessarkansas.org/dfa/ebd
email: askebd@dfa.state.ar.us

STATE OF ARKANSAS
Department of Arkansas and Administration

EMPLOYEE BENEFITS DIVISION
1515 West Seventh, Suite 300
Post Office Box 15610
Little Rock, Arkansas 72231-5610
Phone: (501) 682-9656
http://www.accessarkansas.org/dfa/ebd

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This Guide to Healthcare Choices is provided to help you understand your health care options for the upcoming new plan year and to help you select the option that is best for you. This booklet describes the health insurance plans available, benefits and their corresponding rates.

The month of August is the "Open Enrollment Period" for the public school employees group health insurance program. This is when you are provided information regarding your health insurance for the new plan year through your district's business office. The new plan year starts on October 1, 2002. During the open enrollment period, you may make changes in your plan, add or remove a family member from your plan and even change plans.

Employees with one-year (12 months) prior coverage without a 63-day break in coverage with any health carrier will not be subject to the pre-existing period. Employees who have not had at least 12 months prior coverage should direct questions to your health insurance carrier or carrier you think you will choose. If you do not have any changes to make in your health plan, then no action is required on your part during the open enrollment. Please keep the Guide to Healthcare Choices booklet to reference benefits and contact information throughout the plan year.

If you do have a change, contact your district's business office in order to obtain the appropriate form and make your change. Forms can also be printed from our website, www.accessarkansas.org/dfa/ebd.

Sharon Dickerson, Executive Director

Sharon Dickerson

Employee Benefits Division

Your Health Care Guide

Overview

The material in this guide should make your health care options more understandable, but the information herein is not a contract. Please review this guide before making an enrollment decision. This *Guide to Healthcare Choices* does not and cannot describe every medical/behavioral contingency, or plan provision.

Enrollment

Enrollment for the 2002-2003 school year is characterized as a "passive enrollment." A passive enrollment means you do not have to complete an enrollment form unless you are a new employee or you want to choose a new health insurance plan or, are making a change on your current policy. All employees/dependents who are not covered by a public school employee health insurance plan may enroll during the "open enrollment - August 2002", enrollment period.

You or your dependents cannot be added at any other time during the school year unless you meet one of the following descriptions:

- You or your eligible dependents have lost other health insurance coverage through no action of your own or after the employer providing such other health plan terminated its contribution.
- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

It is YOUR RESPONSIBILITY to notify your District Bookkeeper of any family status change or event that could potentially affect your health insurance coverage. You must request enrollment for yourself or eligible dependents within 30 days after loss of coverage or acquisition of a new dependent. Your school district will provide you with the enrollment form.

Transferring to another district: It is your responsibility to notify the District Bookkeeper of your intent to transfer to another District within 10 days of your resignation or declination of a contract offer. If District is not notified within 10 days, your insurance coverage will be terminated, you will be offered COBRA coverage and you will be subject to the normal waiting period for benefits enrollment at your new District.

Important Dates

If you are an active employee, health insurance enrollment or change forms forms must be completed and returned to your district's business office in August by the due dates they establish. If you are a retiree, health insurance forms must be completed and returned by mail to your chosen health plan with a postmark no later than August 31, 2002. Elections made will take effect October 1, 2002. Enrollment and change forms will be sent to you under separate cover.

Offerings for this Plan Year

- 2 Health Maintenance Organizations (HMO) – Health Advantage and QualChoice/QCA
- 2 Point of Service (POS) – Health Advantage and QualChoice/QCA
- 1 Preferred Provider Organization (PPO) – Arkansas Blue Cross and Blue Shield
- Employee Assistance Plan / Mental Health- StarEAP offered through Corphealth with participation in any of the above health plans.

PPO Facts (Preferred Provider Organization):

- Offers access to the largest network of hospitals, physicians, and other healthcare providers.
- Does not require members to have a Primary Care Physician (PCP).
- Offers wide range of comprehensive healthcare services.

HMO Facts (Health Maintenance Organization):

- Offers wide range of comprehensive healthcare services.
- Provides members with the lowest out-of-pocket expenses.
- Requires members to obtain referral from the PCP to access healthcare from another provider or specialist.
- Provides no benefits to members outside the network. If your PCP wishes you to seek services outside the network, he/she must first obtain a referral from the insurance company.

Remember if you select an HMO, always get a referral from your PCP and stay in the network. There are no benefits outside the network of providers. It is your responsibility to call the insurance company, check the provider manual or look on-line to assure the providers are in the network.

POS Facts (Point of Service):

- Offers wide range of comprehensive healthcare services.
- Requires members to obtain referral from the PCP to access healthcare from another provider or specialist in order to maximize the POS benefit.
- Members can access healthcare services without a referral from their PCP and members can go out of network. The downside is that when going out of network or when not getting a PCP referral, the benefits are subject to the out-of-network deductible and reimbursed at 60% of the maximum allowable amount and NOT the billed rate. Maximum allowable amounts are usually the amount that the insurance company would allow for services provided by their in-network providers. See example on the next page for a hospital stay.

In summary, there are no benefits outside the pure HMO network and limited benefits outside the POS network except for emergency services and authorized referrals. The PPO is an indemnity plan.

Point of Service Out-of-Network (3-day stay)

Hospital billed charges	$6,000.00
Health Plan's allowable (3-day stay @ $800.00 per day)	$2,400.00
Difference (Member's responsibility)	$3,600.00

Health Plan's Financial Responsibility		**Member's Financial Responsibility**	
Health Plan's Allowable Charges	$2,400.00	Health Plan's Allowable Charges	$2,400.00
Less Member's Deductible	500.00	Less Member's Deductible	500.00
	$1,900.00		$1,900.00
Less Member's Coinsurance	760.00	Member's Coinsurance (40% of $1,900.00)	760.00
Health Plan's Financial Responsibility	**$1,140.00**		
		Difference between Billed and Allowed Charges	$3,600.00
		Member's Financial Responsibility	
		Deductible	$ 500.00
		Coinsurance	$ 760.00
		Difference	$ 3,600.00
		Total	**$ 4,860.00**
In this example, the Health Plan pays 19% of billed charges.*		**In this example the Member pays 81% of billed charges.***	

Note: Our health plans are contracted with providers and facilities. If a member accesses services out-of-network (non-contracted provider or facility) the member will be balance billed. Services must be deemed medically necessary by the health plan. If services are not deemed medically necessary, the member will be responsible for the total charges of those services.

In this same example if the member stays in the network the health plan pays $1,520.00 or 63% and the member pays $880.00 or 37%.

Prescription Drug Program

Your prescription drug program is a stand-alone, self-insured plan, which is included with your group health insurance plan and administered by AdvancePCS. Benefits apply equally to all enrollees regardless of the health care plan you choose. You will automatically receive a prescription drug card that offers you important savings on your prescribed medication.

NEW FOR 2002-2003: Front End Deductible and Out of pocket maximum

Effective 10/01/02, you will be required to pay a Front End Deductible (FED) of $50.00 before the plan pays any portion of prescription drug claims. In addition, an annual out of pocket maximum of $2,500.00 has been established. This means each member's maximum out of pocket expense for prescription medications will not exceed $2,500.00 for the plan year. At which time members have accumulated $2,500.00 in prescription co-payments, they will no longer have any pharmacy copayment and the plan will pay for medications at 100% for the remainder of that plan year. The FED of $50.00 does not go towards your maximum out of pocket calculation. FED and out of pocket maximum are applicable to each individual member, not per couple or family.This pharmacy FED does not apply toward medical deductibles or out-of-pocket maximums.

The copays for up to a 34-day supply of medicine, the copayment structure remains:

- $10 for generic drugs
- $25 for "formulary" brand-name drugs
- $50 for "non-formulary" brand-name drugs

The following examples illustrate how the deductible, copay and stop loss work together:

Example #1
First (1st) prescription filled on or after 10/01/02

Medication Cost	$75.00	You pay FED	$50.00
		Preferred brand copayment	$25.00
		Your cost for the first Rx	$75.00

Your next prescription will require the normal copay amount.

Example # 2
First (1st) prescription filled on or after 10/01/02

Medication Cost	$50.00	You pay	FED	$50.00
Preferred Brand	No copayment would apply as you have covered the cost of the drug.			

Next prescription will require only the normal copay amount.

Example # 3
First (1st) prescription filled on or after 10/01/02

Medication Cost	$150.00	You pay FED	$50.00
		Preferred Brand Copayment	$25.00
		Your cost for the first Rx	$75.00

The plan pays the remaining $75.00 cost of the drug. Your next prescription will require the normal copay amount.

New! 4th Tier Benefit
Effective 10/01/02, a "Fourth Tier" benefit will be added to the previous three-tier pharmacy program. In addition to the Generic, Preferred Brand/Formulary, and Non-Formulary categories, Forth Tier medications will now be available at the plan's discounted rate. Fourth Tier medications are medications that previously were not covered at all under this plan, such as weight loss medication, smoking cessation medication and treatments for hair loss. The plan will not pay any portion of the prescription, but you will be able to purchase the medication at the same discount the plan pays to pharmacies in our network. You will be responsible for the cost of the drug at the discounted rate. Such purchases under the Fourth Tier benefit do not apply toward the annual out of pocket maximum, mentioned in the previous paragraph. Purchases must be made at in-network pharmacies using your AdvancePCS ID card.

Selecting a Pharmacy

There are thousands of participating pharmacies nation-wide and most of your local pharmacies will honor your AdvancePCS prescription drug card. For more information about participating pharmacies including pharmacies in other states you can use, contact AdvancePCS Customer Service at 1-877-456-9586.

Should you find it necessary to fill prescriptions at a non-participating pharmacy, the following procedure will be in place effective October 1, 2002:

- You must pay the entire cost of the prescription at the point of sale because the pharmacy does not recognize our co-pay structure.

- A paper claim must be completed and submitted to Advance PCS along with receipt from the purchase. That claim form can be obtained at the AdvancePCS website, http://ar.advancerx.com.
- After you meet the annual front end deductible (FED) of $50, AdvancePCS will reimburse you the difference between the contracted drug cost and the regular copay for that prescription ($10, $25, or $50). NOTE: The contracted price and the retail price are usually different; you will be responsible for that difference. They will also deduct $1.25 for processing. This charge had previously been paid by the plan but is now the member's responsibility.
- You will save money if you use a participating pharmacy when ever possible. A complete list is available at http://ar.advancerx.com or by calling AdvancePCS customer service at 1-877-456-9586

Pilot Mail Order Pharmacy Program

A mail service prescription benefit was implemented on April 1, 2002. Most long-term medications are available through AdvanceRX.com, including ostomy supplies, insulin and other diabetic supplies. Medications will be filled with a 90 day supply for the cost of 2 standard retail copays. For more information about the mail service benefit or for a complete list of excluded drugs, please call AdvancePCS at 1-877-456-9586 or visit their website, http://ar.advancerx.com.

Managing The Prescription Drug Program

Your prescription drug program is designed to provide the greatest benefit to the entire group of state and public school employees. This program requires Prior Authorization of some medications, Quantity vs. Time (QVT) restrictions that are intended to clarify the usual quantity that constitutes a 34-day supply for particular medications; and Daily Dose Edits in order to eliminate inappropriate utilizations of medications intended for one daily use. The Formulary is a dynamic entity that will change at least every three (3) months. As new drugs become available they may be added to the formulary and other drugs may be removed from the formulary as generic drugs become available. Drugs may also be removed from the formulary and replaced by other drugs deemed to be more appropriate for our membership. For more information contact AdvancePCS toll-free at 1-877-456-9586.

Generic Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug. This saves you and your pharmacy program money. Whenever possible, ask your doctor to prescribe generic drugs.

Other Benefits Your Prescription Drug Program Provides

Your prescription drug program offers other benefits for its members such as:

- Patient Support Program
- Disease State Management and its participating pharmacists
- "Specialty Rx" program to supply injectable medication and supplies (call 1-866-295-2779 for more information and to see if you or a family member qualifies).

AdvancePCS Web Site

A custom AdvancePCS website is now available for our members. The address is www.ar.advancerx.com. The web site offers many features including interactive formulary listing, formulary updates, national pharmacy locator and other member-oriented features. Members can also obtain information on the mail order pharmacy program at this site.

Life Insurance

Benefits

Active Public School employees who participate in any of the health plans sponsored by the State and Public School Employee Life and Health Insurance Board will be automatically enrolled in $5,000 of Basic Group Term Life and Accidental Death and Dismemberment (AD&D) coverage with USAble Life.

In addition to the Basic Group Term Life and AD&D, you are eligible to participate in USAble's Supplemental Life and AD&D program. This program allows you to obtain up to $70,000 in Supplemental Life benefits. (Benefit amounts are based on your annual salary). Also you may elect $2,500 of coverage on each of your eligible dependents.

To determine the amount of Supplemental Life for which you qualify, or for more details regarding your Group Term Life insurance, contact your district's business office.

Enrollment

New employees will have 30 days from their hire date to enroll in the Supplemental Life program without evidence of insurability.

If you are currently insured by the Public School Employee group health plan, but have not elected the Supplemental Life, you may make application by providing evidence of insurability. You do not have to be enrolled in health insurance to be eligible to enroll the Supplemental Life insurance.

Please contact your district office to obtain a Supplemental Life application.

Cost Comparisons for

This chart shows your monthly cost for each of the health care options and basic life. This is the cost to the employee after the

	Medical	Behavioral/EAP	Prescription Drug
Employee Only			
BCBS PPO	$178.59	$4.29	$47.73
QualChoice POS	$181.15	$4.29	$47.73
Health Advantage POS	$173.25	$4.29	$47.73
Health Advantage HMO	$165.89	$4.29	$47.73
QualChoice HMO	$167.03	$4.29	$47.73
Employee & Spouse			
BCBS PPO	$498.28	$8.58	$128.69
QualChoice POS	$505.38	$8.58	$128.69
Health Advantage POS	$483.38	$8.58	$128.69
Health Advantage HMO	$462.84	$8.58	$128.69
QualChoice HMO	$466.00	$8.58	$128.69
Employee & Child(ren)			
BCBS PPO	$321.47	$6.86	$83.92
QualChoice POS	$326.07	$6.86	$83.92
Health Advantage POS	$311.85	$6.86	$83.92
Health Advantage HMO	$298.61	$6.86	$83.92
QualChoice HMO	$300.63	$6.86	$83.92
Employee & Family			
BCBS PPO	$500.05	$14.15	$129.15
QualChoice POS	$507.19	$14.15	$129.15
Health Advantage POS	$485.11	$14.15	$129.15
Health Advantage HMO	$464.51	$14.15	$129.15
QualChoice HMO	$467.67	$14.15	$129.15

Active Employees

state contribution has been applied. It does not include the additional contribution that some districts make for employees.

Life & AD&D	Retirement Subsidy	Total Monthly Premium	State Contribution	Total Monthly Employee Cost
$0.65	$11.20	$242.46	($114.00)	$128.46
$0.65	$11.20	$245.02	($114.00)	$131.02
$0.65	$11.20	$237.12	($114.00)	$123.12
$0.65	$11.20	$229.76	($114.00)	$115.76
$0.65	$11.20	$230.90	($114.00)	$116.90
$0.65	$11.20	$647.40	($114.00)	$533.40
$0.65	$11.20	$654.50	($114.00)	$540.50
$0.65	$11.20	$632.50	($114.00)	$518.50
$0.65	$11.20	$611.96	($114.00)	$497.96
$0.65	$11.20	$615.12	($114.00)	$501.12
$0.65	$11.20	$424.10	($114.00)	$310.10
$0.65	$11.20	$428.70	($114.00)	$314.70
$0.65	$11.20	$414.48	($114.00)	$300.48
$0.65	$11.20	$401.24	($114.00)	$287.24
$0.65	$11.20	$403.26	($114.00)	$289.26
$0.65	$11.20	$655.20	($114.00)	$541.20
$0.65	$11.20	$662.34	($114.00)	$548.34
$0.65	$11.20	$640.26	($114.00)	$526.26
$0.65	$11.20	$619.66	($114.00)	$505.66
$0.65	$11.20	$622.82	($114.00)	$508.82

Public School Employees - Retirees and/or spouses over age 65 with Medicare Part A & Part B - New Rates

Effective October 1, 2002 Public School Retirees 65 years and older with existing medical coverage, or new Public School Retirees 65 years and older with Medicare Parts A and B will receive a lower premium rate on the medical coverage than Public School Employees retirees under age 65.

In order to obtain the lower rates, the follow the following steps must be taken:

1. You must have Medicare Part A **and** Part B.
2. All PSE retirees and spouses age 65 or older with Medicare A and B must send a copy of their Medicare card to their appropriate Health Carrier by August 1, 2002.
3. If the PSE retiree decides to change Health Carriers during Open Enrollment, they will need to notify the current carrier by August 1, 2002 and also attach a copy of their Medicare card to the Change Form. Please note: The retiree must notify the new Health Carrier as Medicare information will not be transferred between Health Carriers.
4. If the PSE retiree has Medicare A and B, but does not notify their current Health Carrier by the appointed date, correct deductions may not be made by the Retirement System for the October premium. Health Carriers will not refund the difference in premium. If the Medicare information is received by the 15th of the month, the lower retiree premium will be deducted the first month following receipt of the information. If the Medicare information is received after the 15th of the month, the lower retiree premium will not be deducted the following month.
5. Retirees reaching the age of 65 after October 1, 2002, will be responsible for sending the Health Carrier a copy of the Medicare card indicating Parts A and B have been purchased. The reduced premium will be deducted the first of the month following the receipt of the Medicare effective date information. Health Carriers will not refund the difference in premium for prior months.
6. The General Medicare Open Enrollment period is from January through March each year for a July 1st effective date. Retirees without Medicare Part B should contact the Social Security Administration about obtaining Part B coverage at 1-800-772-1213. Medicare Part B premiums are monthly and may go up 10% for each 12 month period that you could have had Part B but did not sign up for it, except in special cases.

7. If you change your health care carrier, you will need to notify the Medicare Coordination of Benefits contractor at 1- 800 -999 -1118 with your changes. Please provide the name and address of your health plan, your policy number, the date the coverage changed or stopped and why. You will also need to provide this information for the new health carrier.
8. Please advise your physician and other health care providers about any changes in your insurance coverage or Medicare status.

Please refer to the cost comparison table on the next pages for additional details.

Cost Comparisons for

	Medical	Behavioral/EAP
Employee Medicare Only		
BCBS PPO	$309.18	$2.08
QualChoice POS	$323.56	$2.08
Health Advantage POS	$305.78	$2.08
Health Advantage HMO	$292.80	$2.08
QualChoice HMO	$298.74	$2.08
Employee Medicare & Spouse		
BCBS PPO	$580.65	$4.15
QualChoice POS	$604.21	$4.15
Health Advantage POS	$574.19	$4.15
Health Advantage HMO	$549.79	$4.15
QualChoice HMO	$557.49	$4.15
Employee Medicare & Child(ren)		
BCBS PPO	$429.44	$3.32
QualChoice POS	$447.88	$3.32
Health Advantage POS	$424.70	$3.32
Health Advantage HMO	$406.66	$3.32
QualChoice HMO	$413.38	$3.32
Employee Medicare & Spouse & Child(ren)		
BCBS PPO	$582.24	$6.85
QualChoice POS	$605.98	$6.85
Health Advantage POS	$575.88	$6.85
Health Advantage HMO	$551.42	$6.85
QualChoice HMO	$559.14	$6.85
Employee Medicare & Spouse Medicare		
BCBS PPO	$580.65	$4.15
QualChoice POS	$604.21	$4.15
Health Advantage POS	$574.19	$4.15
Health Advantage HMO	$549.79	$4.15
QualChoice HMO	$557.49	$4.15
Employee Medicare & Spouse Medicare & Child(ren)		
BCBS PPO	$582.24	$6.85
QualChoice POS	$605.98	$6.85
Health Advantage POS	$575.88	$6.85
Health Advantage HMO	$551.42	$6.85
QualChoice HMO	$559.14	$6.85

Medicare Eligible

Prescription Drug	Total Monthly Premium	Retirement Subsidy	Total Monthly Employee Cost
$87.91	$399.17	($88.77)	$310.40
$87.91	$413.55	($88.77)	$324.78
$87.91	$395.77	($88.77)	$307.00
$87.91	$382.79	($88.77)	$294.02
$87.91	$388.73	($88.77)	$299.96
$162.79	$747.59	($88.77)	$658.82
$162.79	$771.15	($88.77)	$682.38
$162.79	$741.13	($88.77)	$652.36
$162.79	$716.73	($88.77)	$627.96
$162.79	$724.43	($88.77)	$635.66
$121.09	$553.85	($88.77)	$465.08
$121.09	$572.29	($88.77)	$483.52
$121.09	$549.11	($88.77)	$460.34
$121.09	$531.07	($88.77)	$442.30
$121.09	$537.79	($88.77)	$449.02
$163.26	$752.35	($88.77)	$663.58
$163.26	$776.09	($88.77)	$687.32
$163.26	$745.99	($88.77)	$657.22
$163.26	$721.53	($88.77)	$632.76
$163.26	$729.25	($88.77)	$640.48
$162.79	$747.59	($88.77)	$658.82
$162.79	$771.15	($88.77)	$682.38
$162.79	$741.13	($88.77)	$652.36
$162.79	$716.73	($88.77)	$627.96
$162.79	$724.43	($88.77)	$635.66
$163.26	$752.35	($88.77)	$663.58
$163.26	$776.09	($88.77)	$687.32
$163.26	$745.99	($88.77)	$657.22
$163.26	$721.53	($88.77)	$632.76
$163.26	$729.25	($88.77)	$640.48

Cost Comparisons for

	Medical	Behavioral/EAP
Employee Medicare Only		
BCBS PPO	$333.75	$2.08
QualChoice POS	$349.27	$2.08
Health Advantage POS	$330.07	$2.08
Health Advantage HMO	$316.05	$2.08
QualChoice HMO	$322.47	$2.08
Employee Medicare & Spouse		
BCBS PPO	$626.63	$4.15
QualChoice POS	$652.21	$4.15
Health Advantage POS	$619.81	$4.15
Health Advantage HMO	$593.47	$4.15
QualChoice HMO	$601.79	$4.15
Employee Medicare & Child(ren)		
BCBS PPO	$463.51	$3.32
QualChoice POS	$483.47	$3.32
Health Advantage POS	$458.43	$3.32
Health Advantage HMO	$438.97	$3.32
QualChoice HMO	$446.21	$3.32
Employee Medicare & Spouse & Child(ren)		
BCBS PPO	$628.62	$6.85
QualChoice POS	$654.10	$6.85
Health Advantage POS	$621.64	$6.85
Health Advantage HMO	$595.24	$6.85
QualChoice HMO	$603.56	$6.85
Employee Medicare & Spouse Medicare		
BCBS PPO	$580.65	$4.15
QualChoice POS	$604.21	$4.15
Health Advantage POS	$574.19	$4.15
Health Advantage HMO	$549.79	$4.15
QualChoice HMO	$557.49	$4.15
Employee Medicare & Spouse Medicare & Child(ren)		
BCBS PPO	$582.24	$6.85
QualChoice POS	$605.98	$6.85
Health Advantage POS	$575.88	$6.85
Health Advantage HMO	$551.42	$6.85
QualChoice HMO	$559.14	$6.85

Not Medicare Primary

Prescription Drug	Total Monthly Premium	Retirement Subsidy	Total Monthly Employee Cost
$79.92	$415.75	($88.77)	$326.98
$79.92	$431.27	($88.77)	$342.50
$79.92	$412.07	($88.77)	$323.30
$79.92	$398.05	($88.77)	$309.28
$79.92	$404.47	($88.77)	$315.70
$147.99	$778.77	($88.77)	$690.00
$147.99	$804.35	($88.77)	$715.58
$147.99	$771.95	($88.77)	$683.18
$147.99	$745.61	($88.77)	$656.84
$147.99	$753.93	($88.77)	$665.16
$110.08	$576.91	($88.77)	$488.14
$110.08	$596.87	($88.77)	$508.10
$110.08	$571.83	($88.77)	$483.06
$110.08	$552.37	($88.77)	$463.60
$110.08	$559.61	($88.77)	$470.84
$148.42	$783.89	($88.77)	$695.12
$148.42	$808.37	($88.77)	$720.60
$148.42	$776.91	($88.77)	$688.14
$148.42	$750.51	($88.77)	$661.74
$148.42	$758.83	($88.77)	$670.06
$147.99	$732.79	($88.77)	$644.02
$147.99	$756.35	($88.77)	$667.58
$147.99	$726.33	($88.77)	$637.56
$147.99	$701.93	($88.77)	$613.16
$147.99	$709.63	($88.77)	$620.86
$148.42	$737.51	($88.77)	$648.74
$148.42	$761.25	($88.77)	$672.48
$148.42	$731.15	($88.77)	$642.38
$148.42	$706.69	($88.77)	$617.92
$148.42	$714.41	($88.77)	$625.64

Cost Comparison for COBRA Participant

This chart shows your monthly cost.

	Medical	Behavioral / EAP	Prescription Drug	COBRA Admin Fee	Total Monthly Premium
Employee Only					
BCBS PPO	$178.59	$4.29	$47.73	$4.61	$235.22
QualChoice POS	$181.15	$4.29	$47.73	$4.67	$237.84
Health Advantage POS	$173.25	$4.29	$47.73	$4.51	$229.78
Health Advantage HMO	$165.89	$4.29	$47.73	$4.37	$222.28
QualChoice HMO	$167.03	$4.29	$47.73	$4.39	$223.44
Employee & Spouse					
BCBS PPO	$498.28	$8.58	$128.69	$12.71	$648.26
QualChoice POS	$505.38	$8.58	$128.69	$12.85	$655.50
Health Advantage POS	$483.38	$8.58	$128.69	$12.41	$633.06
Health Advantage HMO	$462.84	$8.58	$128.69	$12.01	$612.12
QualChoice HMO	$466.00	$8.58	$128.69	$12.07	$615.34
Employee & Child(ren)					
BCBS PPO	$321.47	$6.86	$83.92	$8.25	$420.50
QualChoice POS	$326.07	$6.86	$83.92	$8.35	$425.20
Health Advantage POS	$311.85	$6.86	$83.92	$8.05	$410.68
Health Advantage HMO	$298.61	$6.86	$83.92	$7.79	$397.18
QualChoice HMO	$300.63	$6.86	$83.92	$7.83	$399.24
Employee & Family					
BCBS PPO	$500.05	$14.15	$129.15	$12.87	$656.22
QualChoice POS	$507.19	$14.15	$129.15	$13.01	$663.50
Health Advantage POS	$485.11	$14.15	$129.15	$12.57	$640.98
Health Advantage HMO	$464.51	$14.15	$129.15	$12.17	$619.98
QualChoice HMO	$467.67	$14.15	$129.15	$12.23	$623.20

Contact Information

Arkansas Blue Cross & Blue Shield PPO /Indemnity Plan
P. O. Box 2181, Little Rock, AR 72203
In Little Rock: (501) 378-2437 / Outside Little Rock: (800) 482-8416
M-F 8 a.m. to 5 p.m.
E-mail: publicschoolemployees@arkbluecross.com
Web site address: www.arkbluecross.com

Health Advantage - POS
P. O. Box 8069, Little Rock, AR 72203
In Little Rock: (501) 378-2437/ Outside Little Rock: (800) 482-8416
M-F 8 a.m. to 5 p.m.
E-mail: publicschoolemployees@arkbluecross.com
Web site address: www.healthadvantage-hmo.com

QualChoice/QCA - POS
10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211
In Little Rock: (501) 228-7111 / Outside Little Rock: (800)782-5246
M-F 8 a.m. to 5 p.m.
E-mail: quincy@qcark.com
Web site address: www.qcark.com

Health Advantage - HMO
P. O. Box 8069, Little Rock, AR 72203
In Little Rock: (501) 378-2437/ Outside Little Rock: (800) 482-8416
M-F 8 a.m. to 5 p.m.
E-mail: publicschoolemployees@arkbluecross.com
Web site address: www.healthadvantage-hmo.com

QualChoice/QCA - POS
10800 Financial Centre Parkway, Suite 540, Little Rock, AR 72211
In Little Rock: (501) 228-7111 / Outside Little Rock: (800)782-5246
M-F 8 a.m. to 5 p.m.
E-mail: quincy@qcark.com
Web site address: www.qcark.com

Corphealth – StarEAP
1701 Centerview Dr., Suite 101, Little Rock, AR 72211
(866)378-1645
Web site address: www.corphealth.com

Health Care At A Glance

Important Note: *The only out-of-network services covered under the pure HMO plans are emergency services and insurance company authorized referrals. The Point of Service (POS) out-of-network reimbursement of the health plan to the provider is 60% of the health plan's approved charges, not of the provider or facility's billed charges. See the example on the back page of the Guide to Healthcare Choices.*

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK**
Deductible (First dollar out-of-pocket per plan year)	$500 per person $1,000*** per family	$1,500 per person $3,000*** per family	$0 $0	$500 per person $1,000*** per family
Coinsurance/ Copayment	20% after deductible	40% after deductible	Per office visit: $25 PCP $35 Specialist	40% after deductible of maximum allowable amount
Out-of-Pocket Limit (after deductible/ copays)	$3,000 per person $6,000*** per family	$8,000 per person $16,000*** per family	$1,500 per person $3,000*** per family	$5,000 per person $10,000*** per family
Physician Services	20% coinsurance	40% coinsurance	Per office visit: $25 PCP $35 Specialist	40% coinsurance of maximum allowable amount
Inpatient Physicians Services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Outpatient Physicians Services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Outpatient Services	20% coinsurance	40% coinsurance	20% coinsurance after $100 copay for Outpatient Surgical facility	40% coinsurance of maximum allowable amount
Diagnostic Testing (Lab and X-ray)	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK**
Ambulance $1,000 annual limit	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Inpatient Hospital	20% coinsurance	40% coinsurance	$500 copay plus 20% coinsurance per admission with maximum 3 copays per member per year	40% coinsurance of maximum allowable amount
Preventive Care	Not covered except well-baby and GYN visits 20% coinsurance	Not covered except well-baby and GYN visits 40% coinsurance	Covered $25 PCP $35 Specialist	Not covered except well-baby and GYN visits 40% coinsurance
Mental Health / Substance Care/Physician Inpatient & Outpatient	Covered only through CORPHEALTH Behavioral Health Program (See page 19 for specific details)	Covered only $625 copay + 45% coinsurance	Covered through CORPHEALTH Behavioral Health Program	Covered $35 copay + 25% coinsurance per visit
Dental	Not covered	Not covered	Not covered	Not covered
Home Health Nursing Visits 120 annual visits	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Infusion IV drugs and Solutions	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Routine Vision	Not covered	Not covered	Not covered	Not covered

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK**
Emergency Care	20% coinsurance	20% coinsurance	$100 copay + 20% coinsurance, copay waived if admitted to same hospital	$100 copay + 20% coinsurance, copay waived if admitted to same hospital
Transplants	Must be approved by plan, then 20% coinsurance	Must be approved by plan, then 40% coinsurance	Must be approved by plan, then $500 copay + 20% coinsurance	Not covered
Durable Medical Equipment Annual Maximum $10,000	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
DME Repairs	Must be approved by plan	Must be approved by plan	Must be approved by plan	Must be approved by plan
Physical, Occupational, and Speech Therapy Chiropractic Services and Cardiac Rehabilitation	20% coinsurance (Limited to 60 combined visits per member per year)	40% coinsurance	20% coinsurance	40% coinsurance
Allergies	20% coinsurance	40% coinsurance	20% coinsurance for injections $25 copay PCP $35 copay specialist	40% coinsurance

PLAN HIGHLIGHT 2002-2003	PPO PLAN* IN NETWORK	PPO PLAN* OUT-OF NETWORK	HMO & POS PLAN* HMO & POS IN NETWORK	HMO & POS PLAN* POS OUT-OF NETWORK**
Maternity Benefits	*Physician* 20% coinsurance	*Physician* 40% coinsurance	*Physician* 20% coinsurance, copay for initial office visit	*Physician* 40% coinsurance
	Hospital 20% coinsurance	*Hospital* 40% coinsurance	*Hospital* $500 copay per admission plus 20% coinsurance; subject to the inpatient yearly maximums	*Hospital* 40% coinsurance
Maximum Benefits	No Maximum	$1,000,000	No Maximum	$1,000,000

]

* All benefits listed are subject to approval by the Arkansas Insurance Department.

** Out-of-network benefits apply when you do not visit your PCP or follow the plan's referral procedures when visiting a specialist or hospital. For more specific information about a plan's referral process, contact the plans at the numbers listed on page 12.

*** Two family members must meet the individual deductible or out-of-pocket limit to satisfy the family deductible or out-of-pocket limit.

**** All medical coinsurance applies to the physical health out-of-pocket maximum.

Mental and Behavioral Health Benefits

CORPHEALTH coordinates ALL behavioral health care for Arkansas Public School Health Care enrollees. Your benefit program and network of mental healthcare providers is completely separate from your medical, no matter which medical plan you select. Mental Health and Substance Abuse and a new Employee Assistance Program (EAP) are included in the Behavioral Health Care Benefit.

You must access your behavioral health care benefit by calling the Arkansas Helpline and a CORPHEALTH network provider must deliver your care.

The new benefits include the addition of an Employee Assistance Program (EAP) and a completely redesigned mental health and chemical dependency benefit. The new program provides enhanced access and benefits in both the EAP and mental health and substance abuse benefit coverage. You do not have to obtain a referral from your Primary Care Physician to seek help from the Employee Assistance Program or to access your mental health or substance abuse benefits. All contact with EAP is strictly confidential.

Access is easy. Simply call the **Arkansas Help Line toll-free at 1-866-378-1645** 24 hours a day, 365 days a year.

- You'll have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Telephonic and/or face-to-face sessions with one of the EAP affiliate counselors.
- Pre-certification for mental health and substance abuse treatment.
- Individualized referrals to resources in your community.

The EAP program provides you with short-term assessment and counseling with no copay for you or your covered dependents. The EAP provides immediate access to a clinical assessment and outpatient EAP treatment of up to eight (8) sessions, and/or referral to a behavioral health (mental health or chemical dependency) specialist that is covered under the plan at the benefit schedule summarized on the next page:

The EAP benefits include a complete range of services such as:

Emotional Well-Being

- Personal relationships
- Marriage and family issues
- Divorce and separation
- Coping with violence
- Grief and loss

Addiction and Recovery Assessments & Referrals to Specialists

- Alcohol and drugs
- Gambling
- Other addictions
- Support groups
- Eating disorders

Parenting

- Single parenting and blended families
- Discipline, setting limits and safety
- Child development

Work

- Work and personnel issues
- Adjusting to change in the workplace
- Stress management

Financial

- Budgeting
- Managing credit and collections problems

Legal

- Referral to community resources

Key Things to Remember:

- Always access the benefit by first calling the Arkansas Help Line, 1-866-378-1645.

- **All services require pre-authorization.**

- Information about providers and benefits is available at www.corphealth.com. There will be no benefit for non-CORPHEALTH network providers where the care is not directed by CORPHEALTH, Inc. or is not an emergency.

- Always obtain a referral authorization from your CORPHEALTH case manager by calling the Arkansas Help Line at 1-866-378-1645.
- Refer to the *Behavioral Health Care At A Glance* below:

	Benefit Description	In-Network	Out-of-Network
I.	Employee Assistance Program (EAP) Telephonic Consultation and Face-to-Face Short Term/Brief Issue Resolution Counseling	Up to eight (8) EAP sessions per episode with no copayment. Must call Arkansas Help Line at 1-866-378-1645.	Not covered
II.	Initial Behavioral Health Benefit	Must call Arkansas Help Line at 1-866-378-1645.	Not covered
	Deductible:	$0 Individual $0 Family	$0 Individual $0 Family
	Copayment for Traditional Out-Patient Services	$35 copay/ office visit	$35 copay + 25% coinsurance
	Out-of-Pocket Maximum (After copays and deductibles)	$1,500 Individual $3,000 Family	$1875 Individual $3750 Family
	Out-Patient Services (Partial hospital / day treatment)	$100 Copay + 20% coinsurance	$125 copay first visits + 45% coinsurance
	Out-Patient Services (Intensive Outpatient)	$100 Copay + 20% coinsurance	$125 copay + 45% coinsurance
	Residential Treatment	20% Coinsurance	45% coinsurance
	In-Patient Services	$500 Copay + 20% coinsurance per admission	$625 copay + 45% coinsurance/admit

Visit the CORPHEALTH web site at www.corphealth.com

All mental health or substance abuse services, must be preauthorized by CORPHEALTH prior to receiving care.

All mental health and substance abuse claims for care rendered must be submitted to:

Claims Department
CORPHEALTH, Inc.
1701 Centerview Dr., Suite 101 Little Rock, AR 72211

Inpatient

For all enrollees receiving inpatient care in an acute, partial hospitalization, residential treatment or intensive outpatient program level of care, the current Health Plan is responsible for managing the care and processing the claim until the enrollee has been discharged from that level of care. You must call CORPHEALTH at 1-866-378-1645 to precertify any care that may be necessary after you are discharged from any of the above-mentioned treatment levels.

Please contact the Arkansas Help Line toll-free at 1-866-378-1645 (7 days a week, 24 hours a day) if you have additional questions.

Questions & Answers

ACTIVE EMPLOYEES

Q1: If I'm an active employee not currently participating in the Health Insurance Program, may I enroll now?

A: Yes. If you want health insurance coverage this year, you must enroll during this enrollment period. Unless you or your dependents qualify under the following federal laws, you cannot enroll during the remainder of the school year:

- You or your eligible dependents have lost other health insurance coverage through no action of your own.
- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

NOTE: Voluntary termination from another plan does not qualify you to enroll in this plan.

Q2: Do I have to complete a new enrollment form this year?

A: Not if you want to remain in your current health insurance plan.

Q3: What if I want to change my health insurance plan?

A: Submit your completed enrollment form to your school district's business office. Your district should provide you with the forms as well as the due date, which will be sometime in August. New referrals must be obtained when changing from one insurance carrier to another.

Q4: If I change to a new plan during enrollment, will I be subject to pre-existing condition limitations?

A: Once your pre-existing condition period has been satisfied under your current public school plan, you will not be subject to a new pre-existing period when changing plans. When changing from one health plan to another, always complete section 6 of the enrollment form to avoid possible claims denied for pre-existing condition.

Q5: Are the network providers in my current plan remaining the same?

A: There are frequent changes in every network; therefore, please check the provider directories or – for the latest network information – call the plans or visit their web sites. (See page 12 for telephone numbers and available web site addresses.)

Q6: Do I have to select the same PCP for my entire family?

A: No. Each member of your family may select a different primary care physician (PCP). QualChoice requires their female members over the age of sixteen (16) to select two (2) PCP's. One for physical health and one for gynecological care. Family Practice and Internal Medicine physicians can be both physical health and gynecological PCP's.

Q7: May I change my PCP at any time?

A: Yes, but because each plan has its own guidelines, you should contact the POS or HMO plan in which you are enrolled

Q8: What is the difference between a "Pure HMO" and the POS plans offered?

A: A pure HMO offers no out-of-network benefits except in cases of dire emergency or special insurance company pre-authorized out-of-network referrals. An HMO requires a member to obtain a referral from their Primary Care Physician. If referrals are not obtained from the Primary Care Physician the claim will be denied. POS plans offer an HMO benefit when an insured stays in network with a PCP referral, but also offers reduced benefits when the insured seeks specialty services without a referral.

The POS benefit is generally designed for insureds that want the flexibility to access health care both in-network (with PCP referral) and out-of-network without obtaining a referral from the Primary Care Physician. The POS benefit allows you to go out-of-network, just remember that 60% of maximum allowable payment is not 60% of billed charges. The POS benefit can be used for members who reside out of state also, because you can use providers that are not in the network. The HMO is not

designed for members who live out of state, as there are no benefits outside the network. Most networks are only statewide. There are a few exceptions to that rule if you reside in a border city such as Texarkana, West Memphis, etc. Please contact your specific HMO carrier to determine if networks are available to you in the border cities.

Q9: What is a PPO and how does a PPO differ from an HMO and POS?

A: A PPO is an Indemnity Plan. In a PPO Plan, a member has a separate deductible and a separate coinsurance for both in and out of network services. The benefit of a the member stays in the wide PPO network, the reimbursement is better than if the member accesses care outside the PPO network.

Q10: Are my child's immunization's a covered benefit?

A: State mandated immunizations are a covered benefit for children up to age 18. Some adult immunizations, are a covered benefit. Contact your insurance plan if you have questions about immunizations.

Q11: How can my children who are away at college in-state access my POS or HMO Plan?

A: Routine non-emergency medical services are paid according to "in" and "out-of-network" rules. A network provider located in the college town qualifies as "in-network," just like a hometown in-network physician. We recommend your child select a PCP in the college town. Emergency services, regardless of the provider used, are paid "in-network". Charges incurred at a school infirmary are not covered.

Q12: How can my children who are away at college out-of-state access my POS or HMO Plan?

A: Routine healthcare benefits for college students out-of- state will be limited or non-existent and the HMO would be the least favored plan for out-of-state college students. Health care benefits are available in the POS plan just remember that the POS benefit reimburses at 60% of maximum allowable amount rather than 60% of billed charges after deductible is met. Therefore, for a college student out of state, this

plan does provide some limited benefits. Call your health insurance carrier to inquire if a guest membership is available for out of state students. The PPO plan is the best plan to have for out-of-state college students.

Q13: If my PCP pulls out of the network that I am enrolled in after the enrollment period, may I change plans?

A: Plan changes mid-year are rarely allowed. Only in cases of documented lack of access to providers will a mid-year enrollment be permitted. For example, in the event that a county loses all of its network providers in a particular plan, a "special" re-enrollment would permit all plan participants in that county to select another plan.

Q14: How do I enroll in the Supplemental Life program offered by USAble Life?

A: New employees will have 30 days from their hire date to enroll in the Supplemental Life program without evidence of insurability. You may apply for Supplemental Life even if you are not enrolled in the Health Plan. If you are currently insured by the Public School Employee group health plan, but have not elected SupplementaL Life, you may make application by providing evidence of insurability. If you are not enrolled in the Public School Employee group health plan and wish to enroll in the Supplemental Life Plan you may make application by providing evidence of insurability. Please contact your district office to obtain a Supplemental Life application.

Q15: How much Supplemental Life may I apply for?

A: The Supplemental Life is bracketed by salary. Your district office can advise you on the amount you may carry.

Q16: Are diabetic supplies covered?

A: Yes. Diabetic supplies are covered through AdvancePCS, Inc. Glucometers are covered by your health carrier.

RETIRED EMPLOYEES

Q1: Can retirees who dropped coverage in the past come back on the plan during the enrollment period?

A: No. Coverage dropped by retirees cannot be reinstated unless they lose eligibility for coverage under another health plan.

Q2: Do retirees who wish to remain in the same plan need to complete a form this year?

A: No.

Q3: What if I want to change my health insurance plan?

A: Submit your completed form to the Health Plan with a postmark no later than August 31, 2002.

Q4: May I change my insurance plan if I retire after August 31, 2002?

A: Plan changes can be made only at "open enrollment" unless you have a life changing event that qualifies you for a "special enrollment.

Q5: What if I select COBRA rather than the retirement plan?

A: If you select COBRA you must stay on COBRA your entire eligibility period to qualify for insurance through the Retirement Program. COBRA participants lose the life insurance benefit. This benefit will not be reinstated when you go to the retirement group. Your COBRA carrier will bill you monthly. If your COBRA benefits are terminated for non -payment or late-payment, you will not be eligible for insurance through the retirement program.

Q6: How will my retirement premiums be billed?

A: Your premium will be automatically deducted from your retirement check every month. If your retirement check does not cover the premium cost, you will receive a monthly billing from your insurance carrier showing the amount due each month and the due date.

Q7: What if I have Medicare?

A: As a retired insured, you are eligible to continue your public school medical insurance after Medicare begins. When Medicare commences, it will become your primary coverage and claims will be filed with Medicare first. Please check with the health plan you select to determine how it coordinates with Medicare. Also, please remember that Medicare coverage is very limited. Most of your pre-

scription drugs will be covered by your state prescription drug program. Retirees must have both Part A and Part B Medicare. QualChoice requires a Medicare recipient to have Part B. If they do not, QualChoice will pay as if they do have Part B. Please refer to page 14 for further information on retiree rates and Medicare.

COBRA PARTICIPANTS

Q1: May I change plans if I go on COBRA?

A: COBRA participants are eligible to change plans at "open enrollment." You cannot change plans in mid-year..

Q2: Are the same benefits offered to COBRA participants as to active employees?

A: COBRA participants have the same pharmacy and medical benefits as active and retired employees. Life insurance is not available to COBRA participants, through this health plan. Contact USAble Life for conversion options.

CORPHEALTH/STAREAP

Q1. What is the difference between the EAP and Managed Care benefit?

A1. StarEAP is designed to help you resolve short term problems related to work, relationships, parenting, finances, school, elder care, etc. And does not require

Managed Care is designed to address medically diagnosed mental health problems which require treatment for a period of 3 months or more. Treatment can include medication, psychiatric/psychological evaluation, individual, group or family therapy. You receive unlimited sessions, as long as they are medically necessary. There is a co-pay.

Q2. Do I have a choice of providers?

A2. Yes. There are licensed clinicians (master's level, doctorate level and MDs) throughout the state and you can go to any provider in the Corphealth network, statewide. You can call Corphealth directly or go to their website www.corphealth.com for a current list of providers.

* If you require medical care for a mental health problem you must use a hospital that is in your medical plan's network.

Q3. Is my family eligible for mental health benefits?

A3. School employees are eligible for StarEAP benefits if enrolled. Family members can participate in couple or family sessions with the employee. Enrollees in the health plan and their enrolled dependents are eligible for managed care benefits.

Q4. Will my employer know if I use StarEAP?

A4. Your use of the EAP benefit is strictly confidential. In order for information about your participation in the EAP to be released to anyone, you must sign an authorization to release information. Employers can refer you to the EAP if they feel it can be of help to you, if they are concerned about your work performance or if you have a drug free work policy and test positive for a drug screen. Employer referrals to the EAP may require your participation in the EAP, but again, **you must sign a release in order for your information to be shared with your employer.**